While I employ the long splint known as the Davis Taylor splint, and while I find this very satisfactory, I am convinced that it is not so satisfactory outside of large cities, or, at least, away from instrument makers. The difficulty in securing a fit, a knowledge of the details, putting on adhesive plaster for instance, adjusting the perineal straps, getting the pelvic band at the proper angle with the stem, getting the stem sufficiently long—all these points require a little practice, and he who seldom sees cases does not get this practice. I am in the habit, therefore, of advising for country practice a plaster of Paris bandage, applied from the calf up over the hip in the shape of a spike, extending up to the free ribs. Then put the patient on a high shoe for the sound foot, and a pair of axillary crutches. This secures protection to the joint, maintains the limb in good position and approximates, as nearly as we can approximate, that great *desideratum*—absolute and unqualified rest to the joint. The old opinion prevails, I find, throughout the country, that immobilization produces ankylosis. This is a fallacy. Ankylosis is produced not by immobilization, but by imperfect immobilization. The slight amount of motion that is allowed in all splints is just enough to induce adhesions about a joint, and these adhesions are what produce the ankylosis. I have long since demonstrated that the best protection against ankylosis is immobilization while the disease is present. If the case be taken early, before deformity has arisen, there is no occasion for any deformity occurring. Plaster and felt, or anything that maintains the limb in a normal position and maintains it for a long time, will be a powerful factor in resolution. If deformity is present, then secure the limb in the plaster at the angle found. After a week or two the plaster can be removed, and the deformity with a little manual force, and without pain, be reduced to a certain extent. Secure this by plaster, and later on gain more motion and a better position. I am aware that there are plaster bandages, and plaster bandages. I am aware that very few men know how to put on a plaster of Paris bandage, but still this does not prevent me from urging them to learn how to apply a bandage. A skin-fitting bandage can be applied just as well as one with a lot of cotton intervening. The main thing is to have good plaster that sets well and is fine in quality. The best plaster is known as the Dental Plaster. The Dental Manufacturing Company supplies this in six or twelve quart cans, hermetically sealed. It needs to be kept dry, and then salt and alum are unnecessary. Next in importance is a good crinoline bandage. The salient points may be protected by cotton batting, but this should not be thick. The bandage should be rubbed plentifully and be rubbed glossy, and then all inequalities will have been rubbed out. I have treated a number of cases of double hip disease by this method, and the results have been gratifying in the extreme. Time and again I have redueed a deformity by immobilizing the joint in plaster for a few weeks. I do not expect to cure a case in a short time. The case must be managed. If abscesses form and become alarming, then get rid of the abscess by incision and evacuation. If the abscesses give rise to no constitutional disturbance, or pain, or inconvenience, especially, do not take fright and make a grave prognosis, but let the abcess take care of itself. Many cases open spontaneously and good results are obtained. Bad results take place because the joint is not protected, not because the abscesses are present, but because the bone and joint are not attended to. The question of excision of the joint or gouging I shall not discuss, because I see many surgeons about me who are more competent to discuss this matter, and shall close my remarks by urging upon you the importance of early diagnosis—the diagnosis made before any deformity has arisen, the importance of regarding the lesion as tuberculous, the importance of protecting the joint first, last, and all the time.

In conclusion, I trust none of my hearers will accuse me of belittling the so-called American mode of traction with motion. I simply say that traction with motion is not only bad practice, but it is difficult to obtain. My observation is that those who employ this method do it only in name, not in practice. The joints of the splint are usually rusty, and the patients are not taught how to keep them in order. Good results are obtained by the traction. The traction produces fixation. With fixation and traction to the joint, therefore, we have the best attainabie treatment. I employ traction in all